

10 CFR 50.73

RA-14-095

November 11, 2014

U. S. Nuclear Regulatory Commission Attn: Document Control Desk Washington, DC 20555 - 0001

> Oyster Creek Nuclear Generating Station Renewed Facility Operating License No. DPR-16 <u>NRC Docket No. 50-219</u>

Subject: Licensee Event Report (LER) 2014-003-00, Technical Specification Prohibited Condition Caused by Emergency Diesel Generator Inoperable for Greater than Allowed Outage Time

Enclosed is LER 2014-003-00, Technical Specification Prohibited Condition Caused by Emergency Diesel Generator Inoperable for Greater than Allowed Outage Time. This report is submitted in accordance with 10 CFR 50.73(a)(2)(i)(B), any operation or condition prohibited by the plant's Technical Specifications.

This event did not affect the health and safety of the public or plant personnel. This event did not result in a safety system functional failure. There are no regulatory commitments made in this LER submittal.

Should you have any questions concerning this letter, please contact Michael McKenna, Regulatory Assurance Manager, at (609) 971-4389.

Respectfully,

Jeffrey P. Dostal Plant Manager Oyster Creek Nuclear Generating Station

Enclosure: NRC Form 366, LER 2014-003-00

cc: Administrator, NRC Region 1 NRC Senior Resident Inspector - Oyster Creek Nuclear Generating Station NRC Project Manager - Oyster Creek Nuclear Generating Station

NRC FOF	IRC FORM 366 U.S. NUCLEAR REGULATORY COMMISSION APPROVED BY					ED BY OMB: NO	D BY OMB: NO. 3150-0104 EXPIRES: 01/31/2017									
(See Page 2 for required number of digits/characters for each block)					Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the FOIA, Privacy and Information Collections Branch (T-5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to Infocollects.Resource@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.											
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run, when alarms "EDG 2 ENGINE TEMP HI" and "EDG 2 DISABLED" were received. Operations manually shut down EDG-2 due to an apparent cooling problem with the diesel engine. During initial troubleshooting, the fan duct was opened to access the upper fan shaft and it was found that the cooling fan shaft had failed. Without the fan in service, radiator heat transfer performance was degraded, leading to high jacket water (coolant) temperatures and associated alarms.

On September 12, 2014, an Equipment Apparent Cause Evaluation (EACE) for the fan shaft failure was completed. The EACE determined that the remaining shaft life would have met the 24-hour mission time of approximately four test cycles or approximately 43 days prior to the failure. Based on the EACE determination, EDG-2 would not have been able to meet its mission time of 24 hours for approximately 43 days, which is greater than the Technical Specifications (TS) Allowed Out of Service Time (AOT) of seven days.

Therefore, this issue is reportable under 10 CFR 50.73(a)(2)(i)(B) as an Operation or Condition which was Prohibited by the plant's Technical Specifications.

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NARRATIVE							
On July 28, 2014, Emergency Diese load test run, when alarms "EDG 2 manually shut down EDG 2 due to a troubleshooting, the fan duct was o shaft had failed. Without the fan in jacket water (coolant) temperatures	el Generator No. 2 ENGINE TEMP H an apparent coolir pened to access t service, radiator h and associated a	2 (EDG-2) wa II" and "EDG ng problem v he upper fan heat transfer llarms.	as being operate 2 DISABLED" with the diesel en shaft and it wa performance wa	ed for its b were recei ngine. Du s found th as degrade	i-weekly ived. O uring init at the co ed, lead	y one-he peratior tial ooling fa ling to h	our IS an igh
Oyster Creek Nuclear Generating S is to provide AC power to the Class provide this power rapidly, within 10 If started with a fast start signal, a h The EDG units are General Motors cylinder, 2-cycle, turbo-intercooled The EDGs are installed in enclosure with the radiators in duct compartm a large fan at the south end of the e turn rotated by a power-takeoff sha bearing retainer is mounted. The fa retainer and as such, would not be Analysis of Event	tation is equipped 1E busses upon) seconds, upon d igh jacket water to Corporation, Elec diesel engines, wh es inside the EDG ents over the eng enclosure. The far ft connected to the ilure location coul- identified on oper	d with two ide a loss of the lemand. Thi emperature of tromotive Di nich drive the vaults. Eng ines. Coolin i s supporte e engine. Th d not be visu ator rounds of	entical EDG unit off-site power. s condition is re condition will no vision (EMD) M eir respective El jine auxiliaries r g air to each en d and rotated by ne failure locatio ally inspected v or normal mainte	s. The fun The EDG i ferred to a t trip the E odel EMD VD A20C i etain a loc gine is dra / a belt-dri in was at a vithout ren enance.	action of must be s a fast DG. 20-645 AC gen comotive awn into ven sha a groove noving t	the ED able to start sign E4, 20- erators. e-type la this due fit that is in which he bear	Gs gnal. ayout ct by s in ch a ing
Following the event, a complex troumodes. Bearing issues, bent fan st considered. Some of the follow-up failure analysis. Consequently, the PowerLabs (PL) for examination. PowerLabs Report Summary Laboratory evaluations indicated the revealed that based on the smooth, area (approximately 10-20% of the fatigue mechanism. The cracking in stress concentrator. Multiple ratche	bleshooting team haft, fan imbalance actions to support shaft section and e shaft failure was flat, and planar fr total fracture surfa hitiated at the shaft t marks (which ar	was formed es, metallurg t or refute po- bearing part s caused by t racture surfa ace), propag t groove diar e indicative o	to identify and pical defect, and possible failure m to were quarant rotational bendin ce features and ation occurred b neter transition, of multiple crack	investigate incorrect odes requ ined and s ng fatigue. relatively by a high c , which wo c planes) w	e possib belt ten ired lab ent to E small fir cycle-lov uld act vere obs	igations at over w stress as a hig	e re load
PL also noted that the bearing cont shaft. There was no misalignment of base and bolt holes were not worn,	ained minor dame of the roller paths which suggested	contributed t age that was on the inner the base wa	o the failure init considered colla or outer races. I s secured durin	ateral dam In addition In operatic	age fro , the pill n.	m the fa	ailed xk

U.S. NUCLEAR REGULATORY COMMISSION (01-2014) LICENSEE EVENT REPORT (LER) CONTINUATION SHEET

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NARRATIVE

Findings presented in the PL report lead to a review of fan belt tension, which was initially identified as a potential failure mode. Per Maintenance procedure MA-OC-86103-100, "Diesel Generator Fan Belt Replacement," belt tension is set at 60Hz (~5800 lbs hub load equivalent). This setting was discussed with Engine Systems Incorporated (ESI) and found to be 37% higher for the fan horsepower requirement. Technical Evaluation 01686101-06 concluded 47.4 ±2 Hz (~3600 lbs hub load equivalent) is an appropriate setting

Structural Integrity Associates (SIA) was consulted to perform a stress analysis to determine potential causes that could further explain why the fan shaft failed. Additionally, they were asked to analyze fatigue crack initiation and growth, and to determine at what point in the EDG-2 operating cycle the fan shaft had remaining life of 24 hours (EDG mission time).

Structural Integrity Associates Report Summary

SIA investigations revealed that crack growth occurred during the last test run (less than one hour). Beachmarks, features that typically define stops and starts of fatigue crack growth, combined with simulated crack growth data show that the shaft failure would have happened during the last load test. The remaining shaft life would have met the 24-hour mission time approximately four test cycles or approximately 43 days prior to shaft failure.

SIA investigations indicated that a hub load of 5800 lbs. would produce stresses in the reduced (shaft groove transition) section of the shaft of 19.15 ksi, which is at or just below the endurance limit of the shaft material. Endurance limit is defined as the amplitude (or range) of cyclic stress that can be applied to the material without causing fatigue failure. A slight increase in stress for whatever reason would cause the predicted fatigue life to move from infinite to approximately 250 hours based on a change for 19.15 ksi to 20.5 ksi, (about 165 tests). A smaller stress increment above the 19.15 ksi, or smaller, non-continuous time above the 19.15 ksi (e.g., run starts at full belt tension plus stress increment; over time belt loosens slightly to drop stress below 19.15 ksi) would increase the number of cycles and tests to crack initiation.

SIA concluded that at the loads the shaft might experience, fatigue life (both initiation and growth) would be very sensitive to small changes in the load or Stress Concentration Factor (SCF), a dimensionless number used to quantify how concentrated the stress is in a material. The stress amplitude at some point in time must have been higher than 19.15 ksi or that SCF is higher than three for the crack to initiate. SCF is affected by the dimensions of shaft transitions, such as the bearing groove; the smaller the radii or fillet, the higher the SCF.

SIA determined the potential causes of rotational bending fatigue as: 1) Hub loading exceeded the material properties, or 2) defect that produced a stress riser at the groove location (more notched or angular versus a U-shape with radius bends). Either condition could result in stress conditions where the SCF exceeds its design limit of less than or equal to three.

Cause of Event

When reviewing the timeline for potential causes in support of SIA's conclusions, two instances were found worth considering, a fan shaft failure in 1993 and added belt tension in 2005. First, the shaft failure in 1993 shows how susceptible the bearing grooves locations are to imperfection. Questions regarding design details and manufacturing practices were discussed with ESI. Design information, such as dimensions, is limited to vendor manual references, and specifics of bearing retaining groove, as stated by ESI, was left at the discretion of the machinist.

Second, the then recommended tension frequency of 60 Hz is important because it increases the likelihood of the shaft exceeding the endurance limit due to reducing stress margin. An important result from the SIA investigations is that 60 Hz of tensioning frequency, although very high, was most likely not enough to single-

U.S. NUCLEAR REGULATORY COMMISSION U.S. NUCLEAR REGULATORY COMMISSION LICENSEE EVENT REPORT (LER) CONTINUATION SHEET 1. FACILITY NAME 2. DOCKET 6. LER NUMBER 3. PAGE

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NARRATIVE

handedly cause the failure. It was noted that 60 Hz corresponds to approximately 19.15 ksi of stress, which is at or just below the endurance limit. If the shaft was consistent in diameter and stress relief contour profile throughout, it could effectively operate over an infinite number of cycles. Therefore, the plausible failure mode is attributed to manufacturing deficiency or imperfection such as a scratch or nick that increased the stress above the endurance limit. A manufacturing deficiency is the more likely of the two causes based on that fact the PL investigation found no instances of imperfections. Furthermore, the EDG sets are adapted from transportation engines. The original Equipment Manufacturer Design (EMD) was qualified for safety-related service and subsequent parts procured through companies such as ESI. The shafts in service as well as spares were provided to the plant in the late 1960s. Discussions with ESI indicated limited information (dimensions and material) was on file for shaft part number 8441753. In addition to stress relief contours, other factors such as surface finish, heat treatment, etc., can affect material fatigue resistance.

The apparent cause of the failure was found to be higher than average stress concentration factor due to manufacturing deficiency at the grooved location.

The high cycle fatigue mechanism as evaluated by PL and SIA concluded that either excessive hub loading (belt tension) or a notch type defect were the most likely failure mechanisms. It is important to note that the SIA report data approximates material properties of the shaft. Design and fabrication variables such as material hardening, surface finish, EMD shaft design process, machinist proficiency, etc. are variables whose combined impact cannot be assessed.

ESI indicated that limited detail is available on the shaft design, including control of parameters such as stress relief profiles, and finish. Further, control of the groove profile was left to the skill of the fabricating machinist. Minimal design data also challenges the ability to assess shaft health. It is likely that the failed shaft had lower stress margin due to unfavorable variances in fabrication. This condition would have lowered the margin between operational stresses and design stresses leading to its transition from infinite endurance to a finite life from installation in 1993 to end-of-life in 2014. Therefore, a deficiency in the groove profile fabrication is the most likely cause for the shaft failure.

Contributing to the failure was that belt tension, as outlined in station procedure, did not provide adequate margin necessary to address stress risers at the notch.

In 2005, Maintenance procedure MA-OC-86103-100 was issued to specify the 60 Hz belt tension setting, but no technical evaluation was performed or vendor document referenced to review this setting. The 60 Hz belt tension setting is excessive; which resulted in:

- A. Reduced margin to the shaft stress design limits.
- B. A possibility that the belt was tensioned to a point where hub loading combined with stress risers originating from control of the groove configuration exceeded the shaft fatigue endurance limit.

The following immediate actions were taken:

- Replaced EDG-2 fan shaft.
- Performed Ultrasonic Testing of the EDG-1 fan shaft.
- Obtained failure Analyses for failed fan shaft (PL and SIA).
- Performed technical evaluation to specify correct fan belt tension.
- Performed a "Deep Dive" check-in assessment of station EDG maintnenance and operating strategies.

Corrective Actions

NRC FORM 366A

(01-2014)

LICENSEE EVENT REPORT (LER) CONTINUATION SHEET

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NARRATIVE

In order to address the Apparent Cause the following actions were (or are being) taken:

- Repaired EDG-2 failed fan shaft by completing a work order to replace the shaft.
- The EDG-1 fan shaft will be replaced by May 15, 2016. •

In order to address the Contributing Cause the following actions were (or are being) taken:

- Technical Evaluation was performed to determine the correct belt tension for both EDG-1 and EDG-2
- Re-tensioned EDG-1 and 2 fan belts based on Technical Evaluation. .
- Revise station procedures to incorporate correct fan belt tension specified in Technical Evaluation.

Previous Occurrences

DR 93-387 EDG-2 Fan Shaft Failure - In August 1993, the EDG-2 fan shaft failed during routine testing. The cause of the failure was a combination of two factors: 1) the existence of a weld overlay in the vicinity of the bearing sleeve attachment that created an extremely hard subsurface layer, and 2) a machined groove immediately adjacent to the bearing sleeve attachment that extended to a depth corresponding to this extremely hard zone. The result was the initiation of a crack that propagated by torsional fatigue until failure.

Component Data

Component	IEEE 805 System ID	IEEE 803A Function
Emergency Diesel Generator	EK	DG